UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
ORLANDO DIVISION

JUDI M. LEGGETT,

Plaintiff,

-vs-

Case No.: 6:02-cv-1032-Orl-22KRS

PROVIDENT LIFE AND ACCIDENT INSURANCE CO., and JOHNSON CONTROLS WORLD SERVICES, INC.,

Defendants.

ORDER

I. INTRODUCTION

In this ERISA[1] case, Judi M. Leggett sues her former employer, Johnson Controls World Services, Inc. ("Johnson"), and Provident Life and Accident Insurance Company ("Provident"), for alleged wrongful denial of short- and long-term disability benefits. Johnson and Provident have filed separate motions for summary judgment, to which Leggett has responded. Upon carefully considering the parties' submissions, the Court determines that the Defendants are due summary judgment.

II. UNDISPUTED FACTS

While she worked for Johnson, Leggett was covered under two employer-provided group disability plans. One was a short-term disability ("STD") plan issued by Provident. Under the STD plan, Johnson was responsible for providing the funds necessary to pay claims; Provident

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[1]Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001 *et seq.*

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served as plan administrator. The other plan was a long-term disability ("LTD") policy issued by Provident, under which Provident was responsible for both claims administration and payment.[2]

Leggett began working for Johnson in late 1993. On May 9, 2001, Johnson notified Leggett that the company was terminating her employment as an assistant auditor pursuant to a reduction in force. Johnson told Leggett that May 11th would be her official termination date, and that May 10th and 11th would be entered as "administrative leave" on her time sheet. Johnson also advised Leggett that it was giving her two weeks pay in lieu of notice of the reduction in force. Accordingly, on May 9th, Leggett packed her belongings, turned in her access keys and employee badge, and left the premises. May 9th was the last day Leggett physically worked at Johnson.[3]

On May 7, 2001, two days before she learned she was to be terminated, Leggett went to see her neurologist, Dr. Richard P. Newman, for what Dr. Newman described as a "new" problem. In his office note, Dr. Newman explained:

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[2]In one of her summary judgment responses, Leggett maintains that Johnson was "responsible for any Long-Term Disability benefits at issue[.]" Doc. 49 at unnumbered p. 16. However, Leggett does not provide a record citation for this statement, which is inconsistent with the terms of the LTD plan.

[3]At Leggett's request, Johnson later converted Leggett's absences for the balance of the day on May 9th following her departure from work, and on May 10th and 11th, to family and medical leave. However, in its letter to Leggett concerning the matter, Johnson stated that it did not believe it was legally obligated to provide Leggett with any family and medical leave, but was doing so "**in order to ensure fairness and prevent any misunderstanding.**" *See* May 15, 2001 letter from Mark A. Gow, Johnson's Director of Benefits and Compensation, to Leggett (attached to Doc. 44) (emphasis in original).

> *[Leggett] is not having any symptoms* but in the last month in a half her sister, age 51, had a ruptured cerebral aneurysm. She has recovered. Ms. Leggett is concerned about any familial tendency. No other family member has ever had an aneurysm. She has migraine headaches as has her sister in the past and as another sibling has. *She is having no trouble with thinking, cranial nerve functions, motor function, other than what she has had before.*

Doc. 32, Ex. B, UPCL00027 (emphasis added). The office note reflects that Dr. Newman conducted a physical examination of Leggett. Beside the heading "IMPRESSION," Dr. Newman wrote: "*She is asymptomatic* except she has hypertension." *Id.* (emphasis added). In the section of the report entitled "RECOMMENDATIONS," Dr. Newman stated: "It would be useful to obtain an MRA of the cerebral circulation without and with contrast to look for aneurysm formation to put this to rest. She needs to follow her blood pressure away from Drs. offices and if it remains elevated, she needs treatment." *Id.*

On May 9, 2001, the same day she was notified she was being laid off, Leggett underwent a limited MRI brain scan. In his report concerning the procedure, Dr. Newman noted: "There is a focal area of increased signal intensity in the right centrum semi-ovale. No mass lesion is seen." *Id.*, UPCL00024. In the "IMPRESSION" section of the report, Newman stated: "Solitary white matter lesion as described. Demyelinating plaque *is likely* in this age group. *Consideration must be given to multiple sclerosis*." *Id.* (emphasis added). Newman recommended "a routine brain examination without and with contrast as well as FLAIR imaging." *Id.* There is no indication from this report that any of these findings or impressions were disclosed to Leggett on May 9th.

The next day (May 10th), Leggett underwent an MRI brain scan, without and with contrast. In his report concerning this test, Dr. Newman stated: "There are multiple focal areas of increased signal intensity primarily in the superficial white matter of both cerebral hemispheres and there is a large one in the right centrum semiovale." *Id.*, UPCL00025. In the "CONCLUSION" section of the report, Newman stated: "1. Abnormal MRI. 2. There are multiple white matter lesions as described *which likely represent multiple sclerosis plaques* in this age group. *Clinical correlation is warranted.* No acute lesion is seen." *Id.* (emphasis added). As with the May 9th report, there is no indication in this report that Leggett was informed on May 10th of her test results or Dr. Newman's conclusions.

The following day (May 11th), Dr. Newman told Leggett over the telephone "about the results of all her studies." Doc. 50, Ex. 9, third document. In his note concerning the call, Newman further remarked that Leggett was "going to need further evaluation including spinal tap." *Id.* That same day - the very day her termination was effective - Leggett submitted an application for STD benefits to Johnson, claiming disability on the basis of multiple sclerosis (MS). *See* Doc. 32, Ex. "B," UPCL00020. In her claim form, Leggett listed May 9, 2001 as the "[d]ate sickness began or injury occurred." *Id.* She identified May 7, 2001 as the "[d]ate of first treatment by physician for present disability." *Id.*

In support of Leggett's claim, Dr. Newman submitted an Attending Physician's Statement of Disability (APS), dated May 10, 2001. *Id.*, UPCL00021. Therein, Dr. Newman listed diagnoses of MS and hypertension. *Id.* He indicated that Leggett had never had the "same or similar condition." *Id.* He listed May 7, 2001 as the date of treatment and indicated

that the treatment was in his office. *Id.* He opined that Leggett was totally disabled from her own occupation and any other work; that May 9, 2001 was the date on which Leggett's total disability commenced; and that Leggett was incapable of performing all of the duties of her occupation. *Id.*

On June 1, 2001, Provident sent Leggett a letter notifying her that it was denying her STD claim. Among other things, the letter noted that "Disability must commence while the Plan is in effect." *Id.*, UPCL00034. It also set forth the STD plan's definition of disability: "You are disabled if due to your Sickness or Injury you are unable to perform each of the material duties of the occupation that you regularly perform for the Employer." *Id.* The letter then explained:

> Based on the information in our file, the medical information does not substantiate total disability. We have received and reviewed the medical documentation supplied by Dr. Newman's office but we have been unable to document the impairment that would necessitate a disability or inability to perform the material duties of you[r] occupation. The results of the MRI show areas that likely represent multiple sclerosis plaques, but Dr. Newman also states that you are not having any symptoms. Dr. Newman also states you have been diagnosed with hypertension but does not give any restrictions or limitations relevant to your sedentary job duties that supports a claim for total disability. Therefore, we are unable to recommend approval of your Short Term Disability claim.

Id. The June 1st letter stated that if Leggett had new, additional information to support her request for STD benefits, she should submit it. *Id.* Additionally, the letter notified Leggett that if she wished to seek review of Provident's decision, she should send the company a written request within sixty days. *Id.*

Thereafter, Dr. Newman's office sent Provident additional medical information, concerning Leggett's office visit with Newman on June 11, 2001. Dr. Newman's office note for that visit states:

> Judi was into [sic] see me for reevaluation today. I went over the findings of the MRI with her. She has multiple white matter lesions, which to me *appear to be multiple sclerosis*. She has hypertension, which has been somewhat difficult to control as well.
>
> She has heat sensitivity and she feels very weak and fatigued when she gets warm. Sometimes her legs are rubbery and give way. Some of the episodes of numbness in the extremities have not been readily or completely explained by the nerve conduction studies. She has never had transient blindness but has had some visual disturbances periodically. She occasionally has double vision. She has no problems with bladder control.
>
> *I believe she probably does have a mild case of MS but I would like to be firm on this* so we can intervene properly.
>
> She needs to have a series of evoke response studies and a diagnostic lumbar puncture.
>
> I still do not feel she is able to return to work on a regular basis and I feel she should be on short term disability.
>
> Tests will be scheduled.

Doc. 32, Ex. "B," UPCL00039 (emphasis added). Additionally, a member of Dr. Newman's staff informed Provident that visual response studies and a lumbar puncture were ordered for Leggett on June 11th. *Id.*, UPCL00041. However, the staffer advised that those tests were not done because Leggett's "medical insurance has been discontinued and she would have to pay for this testing herself[.]" *Id.* It was also reported that Leggett had no follow-up appointment scheduled with Dr. Newman. *Id.*

On July 19, 2001, Provident sent Leggett a letter notifying her that it had determined the additional information submitted by Dr. Newman's office "was not sufficient to reverse our previous decision." *Id.*, UPCL00045. Elaborating, Provident stated:

> We received and reviewed the medical notes from Dr. Newman. Information received from Dr. Newman's office states that you were last seen on June 11, 2001. Dr. Newman states the treatment plan is to have Visual Response Studies and Diagnostic Lumbar Puncture testing done. As of July 3, 2001 the testing has not been done and no follow up appointment has been scheduled with Dr. Newman. The additional information received from Dr. Newman does not show specific restrictions and limitations keeping you from performing the material duties of your sedentary position.

Id. Provident's July 19th letter also noted that Leggett had not specifically requested appellate review, and informed her that if the company "does not receive your written appeal within 90 days of the date of the original denial letter, the claims decision will be final." *Id.*

Thereafter, Leggett sent Provident a letter requesting appellate review.[4] Leggett listed a number of symptoms she said prevented her from "presently" performing the duties of her occupation, including extreme fatigue; high blood pressure; constant pain, particularly in the lower extremities; weakness in the hip and knees, resulting in balance problems and falling; stiffness in the limbs from sitting for extended periods, also resulting in balance problems and falling; constant painful burning sensation in the legs; confusion, short-term memory loss, and

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[4]The date on which Leggett sent the letter is unclear. The handwritten date "7/27/01"appears at the top of the letter, which is otherwise typed. Doc. 32, Ex. "B," UPCL00051. The letter also bears a stamp reading "Quality Performance Support," below which the date "Jul 31 2001" appears. *Id.*

short attention span; blurred and fuzzy vision; light-headedness; problems with spelling and "a major problem with numbers;" difficulty swallowing and choking on liquids; severe headaches; and depression. *Id.*, UPCL00051.

Apparently in conjunction with this letter, Leggett's physicians also sent Provident additional correspondence. In a letter dated July 30, 2001, Dr. Newman stated, in pertinent part:

> [Leggett] can't perform the usual duties of her occupation at this time. She has severe fatigue, the most common symptom of multiple sclerosis[,] and she is worse when she is exposed to heat. She has constant pain in her legs, probably central in origin. She loses her balance and her legs are weak and give out at the knees. She has confusion and short term memory loss. She has blurred vision. She has trouble with executive cognitive functions. She chokes on liquids.
>
> *At this time she is unable to perform any of her duties at work.* Her thinking isn't clear enough. I don't trust her transporting herself to and from the job.
>
> She needs to be on short-term disability.

Id., UPCL00049 (emphasis added).

In a separate letter, also dated July 30, 2001, Dr. Armando O. Martinez advised that he felt Leggett should "have short term disability" "due to multiple sym[p]toms as a result of the underlying diagnosis of Multiple Sclerosis." *Id.*, UPCL00048. Dr. Martinez added: "Neurological evaluation and treatment will establish the long term prognosis of the patient." *Id.*

On August 17, 2001, after considering this information and obtaining a written job description for Leggett's former position at Johnson, Provident wrote Leggett a letter reaffirming its denial of her claim. Concerning Dr. Newman's medical notes, Provident stated

"there is no objective medical information to substantiate the disability." *Id.*, UPCL00062. The letter closed by stating that Leggett's file had been referred to Provident's "Appeals area for an additional, independent review by an Appeals specialist." *Id.*

On August 23, 2001, one of Provident's senior appeals specialists wrote Leggett a letter acknowledging receipt of her correspondence requesting appellate review. *Id.*, UPCL00063. Thereafter, Leggett's case was reviewed by Provident's Senior Medical Director, board-certified family practitioner Dr. Nancy Beecher. Following that review, Dr. Beecher issued a report stating, in pertinent part:

> Summary of findings: The claimant saw Dr. Newman on 5/7/01 and stated that she had no symptoms or cognitive problems, just a history of HA but she was concerned about a brain aneurysm as her sister had just had one bleed. MRA was scheduled and MRI was done as well. The MRA was WNL, and the MRI showed some small peripheral white matter lesions. The issue of MS was raised and LP and evoked response testing was recommended. She did not do this but is now claiming all sorts of symptoms and inability to do her sedentary job. Her neurological exam was WNL, as was her mental status exam. Dr. Newman['s] letter of 7/30/01 states that she is unable to work due to all of her symptoms and cognitive complaints. There is no mention of any neuropsych testing. Dr. Martinez says, on the same date, that she is unable to work due to all of her symptoms. She says that she is dizzy, weak, has pain and balance problems, is confused with blurred vision, has cognitive and swallowing problems and that she is very depressed and feels like she doesn't want to go on.

Id., UPCL00067. Based on this information, Dr. Beecher concluded that the clinical data did not support Leggett's contention that she could not perform the usual functions listed in her job description. In that regard, the physician stated: "These are all subjective and self reported complaints and no medical basis has been found for these. I do not see that any neuropsych

testing or other psychological evaluation has been done." *Id.*, UPCL00066. Dr. Beecher added: "It appears all of her symptoms began after she found out her job was going to be eliminated." *Id.*

On October 4, 2001, Provident sent Leggett a letter notifying her that its appellate review was complete and it was upholding the STD claim denial decision. *Id.*, UPCL00068-69. In the letter, Provident cited Dr. Beecher's findings and conclusions, and stated that "the medical information does not support an impairment that would prevent you from performing your occupation[.]" *Id.*, UPCL00068. The letter also stated: "[W]e must rely on objective medical data, rather than subjective complaints, in support of the restrictions and limitations that prevent a person from performing their occupation." *Id.* In closing, the letter informed Leggett that if she wished "to provide any further medical information for consideration, such as any neuropsychological testing or psychological evaluations, you must submit it to our office by November 4, 2001." *Id.*

Apparently in response to this invitation, Provident received additional medical information from Physician's Assistant Janie Phear (who worked in Dr. Newman's office) and from Dr. Martinez. PA Phear's letter stated:

> The above named patient is requesting short-term disability. Since I last wrote on July 30, 2001 the patient has completed her lumbar puncture and evoked response studies. Though *both of these studies were negative*, her MRI shows multiple lesions *characteristic of Multiple Sclerosis* and she has had discreet episodes over time. Therefore, I have started her on Avonex to decrease the frequency and intensity of the exacerbations of her MS.

> In addition, she was seen in our office today and maximization of therapy for her symptoms begun. At this time she is not able to perform her current work duties as she suffers from low energy, short-term memory loss, inability to focus, stuttering, problems with calculations and blurred vision. Despite her sedentary position she would be unable to perform her job for the above reasons. She needs to be on short-term disability.

Id., UPCL00070 (emphasis added).[5]

Dr. Martinez's letter, dated October 22, 2001, stated:

> Please be advised that [Leggett] has been my patient since 1994. During those years the patient has symptoms that *could have been attributed* to Neurological problems i.e. Multiple Sclerosis.
>
> Since the patient has been recently diagnosed with this condition *it is conceivable* that the complaints and findings of the previous years *could have been* directly related to the diagnosis.

Id., UPCL00071 (italicized emphasis added).

Provident treated these submissions as a "reappeal." *Id.*, UPCL00072. Accordingly, on November 1, 2001, Provident sent Leggett another appeal acknowledgment letter. *Id.*, UPCL00073-74. Thereafter, the new information was reviewed by one of Provident's in-house clinical consultants, RN Brenda Nunn. In a report dated November 16, 2001, Nurse Nunn wrote:

> Additional information received from Dr. Martinez in the form of a "To Whom it May Concern," letter dated 10/22/01 & from physician's ass't Janie Phear dated 10/1/01 does not appear to provide support [sic] R&Ls.[6] Both treatment providers have

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[5]This letter was dated October 1, 2001 but was apparently not received until after Provident issued its October 4th appeal denial letter.

[6]Apparently, "R&Ls" is shorthand for "Restrictions and Limitations."

> neglected to include any office notes or diagnostic test results with these letters although Ms. Phear confirms lumbar puncture and evoked response studies are negative while the MRI does show white matter as Dr. Beecher [mentioned] in previous 10/2/01 review. Although Ms. Phear mentions several cognitive problems, there does not appear to be any neuropsych testing administered to support these symptoms.

Id., UPCL00075 (footnote added).

On November 16, 2001, Provident wrote a letter informing Leggett that, after completing its "second and final appellate review" of her STD claim denial, the company was again upholding the denial decision. *Id.*, UPCL00079. In the letter, Provident repeated Dr. Beecher's prior findings and conclusions, and quoted Nurse Nunn's findings. The company then stated: "According to the medical reviews, the medical information does not support an impairment that would prevent you from performing your occupation; therefore we are upholding the decision as outlined in our initial correspondence of July 19, 2001." *Id.*, UPCL00078. The letter reiterated that Provident "must rely on objective medical data, rather than subjective complaints, in support of the restrictions and limitations that prevent a person from performing their occupation." *Id.*

This lawsuit ensued.

III. PLAN PROVISIONS CONCERNING DISABILITY AND DURATION OF COVERAGE

A. STD Plan

The STD plan contains the following definition of "disability": "You are Disabled if due to your Sickness or Injury you are unable to perform each of the material duties of the occupation that you regularly perform for the Employer." Doc. 32, Ex. "A," PLAGP00922.

Concerning the duration of coverage, the STD plan provides that coverage will "automatically cease" on the earliest of several events, one of which is "the date your employment with the Employer terminates." *Id.*, PLAGP00916. However, coverage continues while the covered person is "on a leave of absence under the terms of any state or federally mandated family or medical leave act or law[.]" *Id.*

B. LTD Plan

The LTD plan covers two types of disability: "own occupation" and "any occupation." Doc. 32, Ex. "C," PLAGP00860 & -64. The "own occupation" period is two years; it commences after expiration of the elimination period. *Id.*, PLAGP00864, -60 & -59. The elimination period is 180 days from the date of disability onset. *Id.*, PLAGP00865 & -58. The "own occupation" period is followed by an "any occupation" period that commences at the conclusion of the "own occupation" term but which may not exceed an age-based maximum benefit period. *Id.*, PLAGP00864.

The plan defines "own occupation" disability, in relevant part, as follows:

> During the Own Occupation Period, Covered Persons are Disabled from their own occupation if due to their Sickness or Injury they:
>
> 1. are unable to earn at least the Own Occupation Income Level; or
> 2. are unable to perform each of the material duties of the occupation that they regularly perform for the Employer[.]

Id., PLAGP00860.

The LTD plan further provides that "[t]he Disability must commence while this Policy is in effect." *Id.*, PLAGP00867.

Concerning the duration of coverage, the LTD policy is virtually identical to the STD plan. In that regard, the LTD plan provides that coverage will automatically cease on the earliest of several occurrences, one of which is the date employment terminates. *Id.*, PLAGP00851. Again, however, as in the STD plan, coverage under the LTD policy continues while the covered person is "on a leave of absence under the terms of any state or federally mandated family or medical leave act or law[.]" *Id.*

IV. SUMMARY JUDGMENT STANDARD

A motion for summary judgment should be granted when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c). "The party seeking summary judgment bears the initial burden of identifying for the district court those portions of the record 'which it believes demonstrate the absence of a genuine issue of material fact.'" *Cohen v. United Am. Bank of Cent. Fla.*, 83 F.3d 1347, 1349 (11th Cir. 1996) (quoting *Cox v. Adm'r U. S. Steel & Carnegie*, 17 F.3d 1386, 1396, *modified on other grounds,* 30 F.3d 1347 (11th Cir. 1994), *cert. denied*, 513 U.S. 1110 (1995)). "There is no genuine issue for trial unless the non-moving party establishes, through the record presented to the court, that it is able to prove evidence sufficient for a jury to return a verdict in its favor." *Cohen*, 83 F.3d at 1349. The Court considers the evidence and all inferences drawn therefrom in the light most favorable to the non-moving party. *See Hairston v. Gainesville Sun Pub. Co.*, 9 F.3d 913, 918 (11th Cir. 1993), *reh'g and reh'g en banc denied,* 16 F.3d 1233 (11th Cir. 1994).

V. ERISA STANDARD OF REVIEW

A. Generally

The Supreme Court has held that "a denial of benefits challenged under [29 U.S.C.] § 1132(a)(1)(B)[7] is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan." *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989); *Kirwan v. Marriott Corp.*, 10 F.3d 784, 788 (11th Cir. 1994) (quoting *Bruch*). Amplifying further on this principle, the Court of Appeals for the Eleventh Circuit has stated:

> This circuit has interpreted *Bruch* to mandate *de novo* review unless the plan *expressly* provides the administrator discretionary authority to make eligibility determinations or to construe the plan's terms. Thus, this court has applied the arbitrary and capricious standard when the plan provides that the administrator[']s "determinations shall be final and conclusive" so long as they are "reasonable determinations which are not arbitrary and capricious." This court has also applied the arbitrary and capricious standard when the plan confers upon the administrator "full and exclusive authority to determine all questions of coverage and eligibility" and "full power to construe the provision" of the plan. On the other hand, this court has applied the *de novo* standard when the plan confers upon the administrator the authority to make initial eligibility determinations "according to the terms of the Plan."

Kirwan, 10 F.3d at 788 (emphasis in original; footnotes and internal quotation marks omitted).

If the *de novo* standard applies, a district court reviewing a benefits determination "is not limited to the facts available to the Administrator at the time of the determination." *Kirwan*, 10 F.3d at 789. On the other hand, if the arbitrary and capricious standard applies, "the

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[7]Section 1132(a)(1)(B) authorizes a "participant or beneficiary" to bring a civil action "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan[.]"

administrator's fact-based determinations will not be disturbed if reasonable based on the information known to the administrator at the time the decision was rendered." *Paramore v. Delta Air Lines, Inc.*, 129 F.3d 1446, 1451 (11th Cir. 1997). The arbitrary and capricious standard applies to the administrator's "construction of the plan and concomitant factual findings[.]" *Id.* However, if an administrator who has been granted discretion under the plan has a conflict of interest, a "heightened" arbitrary and capricious standard governs. *Id.* at 1449. Such a conflict of interest exists where a plan is administered by an insurance company which pays benefits out of its own assets. *See, e.g., Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556 (11th Cir. 1990), *cert. denied,* 498 U.S. 1040 (1991). Under this heightened arbitrary and capricious standard,

> "a wrong but apparently reasonable interpretation is arbitrary and capricious if it advances the conflicting interest of the fiduciary at the expense of the affected beneficiary or beneficiaries unless the fiduciary justifies the interpretation on the ground of its benefit to the class of all participants and beneficiaries."

Godfrey v. BellSouth Telecommunications, Inc., 89 F.3d 755, 758 (11th Cir. 1996) (quoting *Brown*, 898 F.2d at 1566-67). This principle is limited by an important precondition: "'[t]he fiduciary's interpretation first must be "wrong" from the perspective of a *de novo* review[.]'" *Godfrey*, 89 F.3d at 758 (quoting *Brown*, 898 F.2d at 1566 n.12).

A. STD Plan

To support its argument that the arbitrary and capricious standard applies to the STD plan, Provident relies on the following plan language:

> If *Provident denies* any part of your claim, you will receive a written notice of denial containing the following information:

1. the reason for *Provident's decision*;
2. reference to the parts of the Plan on which *Provident's decision* is based;
3. a description of any additional information needed to support your claim; and
4. information concerning your right to a review of our decision.

Doc. 32, Ex. "A," PLAGP 00914 (emphasis added). In Provident's view, the emphasized words vested the company with sufficient discretionary authority to compel arbitrary and capricious review. The Court disagrees. These provisions do not even begin to approach the type of language identified in *Kirwan* as sufficient to trigger that type of review. *See,* 10 F.3d at 788. If this were the only pertinent language in the STD plan, *de novo* review would be mandated. However, other provisions of the plan, and contained in the "Short Term Disability Administrative Service Agreement" between Provident and Johnson, necessitate further discussion.

First and foremost, in a section entitled "CLAIM PROVISIONS," the STD plan states: "Proof of Loss means written evidence satisfactory to Provident that you are Disabled and entitled to STD Benefits." *Id.,* PLAGP00914. The phrase "satisfactory to Provident" constitutes a sufficient grant of discretion to compel application of the arbitrary and capricious standard of review. *See Morency v. Rudnick & Wolfe Staff Group Long Term Disability Ins. Plan,* 2001 WL 737531 *2-3 (M.D. Fla. Jan 31, 2001) (No. 8:99CV2688T24MAP) (Bucklew, J.); *Donato v. Metropolitan Life Ins. Co.,* 19 F.3d 375, 379-80 (7th Cir. 1994).[8]

[8]In the course of proposing "safe harbor" discretionary language triggering arbitrary and capricious review, the Seventh Circuit later recognized that while the plan language in *Donato* was not as clear as the suggested safe harbor verbiage, it nevertheless "indicate[d] with the requisite if minimum clarity that a discretionary determination [was] envisaged." *Herzberger v. Standard Ins.*

Further, the STD plan contains a section headed "EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)." Doc. 32, Ex. "A," PLAGP 00913-911. That section begins with this statement: "The following information with the information contained in the preceding Plan Document comprises the Summary Plan Description under the Employee Retirement Income Security Act of 1974 (ERISA) only for the benefits described in the preceding Plan Document." *Id.*, PLAGP 00913. Included in this section is a paragraph entitled "ERISA Claim Procedures." *Id.* That paragraph reads as follows:

> Claims for benefits under the Plan are to be submitted to Provident as provided herein. Payment of claims under the Plan will be made by Provident. If your claim for benefits under the Plan is denied, you will receive a written explanation giving detailed reasons for the denial, specific reference to Plan provisions on which the denial is based, a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, as well as an explanation of the claim appeal procedure.
>
> If you are not satisfied, or do not agree with the reasons for the denial of the claim, you may appeal the decision to the Claims Fiduciary named above.[9] *It is the intent of the Plan Sponsor that the Claims Fiduciary shall have the sole and exclusive discretion and authority to carry out all actions involving claims procedures explained in the Plan. The Claims Fiduciary shall have the sole and exclusive discretion and power to grant and/or deny any and all claims for benefits, and construe any and all*

Co., 205 F.3d 327, 331 (7th Cir. 2000) (further stating that in *Donato*, "the entitlement to benefits was conditioned on submission of proof 'satisfactory to us' (that is, to the plan administrator), and we ruled that the 'to us' signaled the subjective, discretionary character of the judgment that was to be made.").

[9]In a preceding paragraph, Johnson is identified as the claims fiduciary, the plan sponsor, the plan administrator, and the agent for service of legal process. *See* Doc. 32, Ex. "A," PLAGP 00913.

issues relating to eligibility for benefits. All findings, decisions and/or determinations of any type made by the Claims Fiduciary shall not be disturbed unless the Claims Fiduciary has acted in an arbitrary and/or capricious manner. Subject to the requirements of law, the Claims Fiduciary shall be the sole judge of the standard of proof required in any claims for benefits and/or in any question of eligibility for benefits. All decisions of the Claims Fiduciary shall be final and binding on all parties. Whenever a decision on a claim is involved, the Claims Fiduciary is given broad discretionary powers, and the Claims Fiduciary shall exercise said powers in a uniform and nondiscriminatory manner, in accordance with the Plan's terms.

Your appeal **must be in writing** and can be made by you or your duly authorized representative. It must set out the reasons for the appeal and your dissatisfaction or disagreement. Any evidence or documentation to support your position should be submitted with your written appeal. Upon written request, you may review pertinent documents that pertain to your claim and its denial.

Your appeal must be made within sixty (60) days of the date of receipt of the letter denying the claim.

The Claims Fiduciary will promptly review the claim and appeal. The Claims Fiduciary will advise you of its decision with specific references to pertinent plan provisions on which the decision is based. This written decision will be sent to you no later than sixty (60) days after the Claims Fiduciary's receipt of your written appeal, unless special circumstances require an extension of time for processing the appeal, or obtaining more information or conducting an investigation of the facts. In no event will the written decision be sent later than one hundred twenty (120) days after your written appeal is received.

Id., PLAGP 00913-912 (footnote and italicized emphasis added).

The emphasized language constitutes an unmistakable grant of discretionary authority sufficient to invoke the arbitrary and capricious standard of review. However, that authority is granted to the "Claims Fiduciary," which is identified as Johnson, not Provident. Further, the

emphasized language pertains to appeals, rather than initial claims decisions. It is undisputed that Provident made all of the claims denial decisions in this case, including appellate review. This might be problematic had Johnson not delegated substantial authority over claims to Provident via the Administrative Service Agreement ("ASA"). *See* Doc. 32, Ex. "D," PLAGP00938-936.

The ASA set forth the basis upon which Provident was to provide administrative services regarding the STD plan. In the ASA, Johnson agreed to, *inter alia,* "[d]etermine the claims administration procedures and practices to be followed which are not self-evident from the Benefit Program." *Id.*, PLAGP00938. Provident's responsibilities under the ASA included "[f]ollow[ing] the claims administration procedures and practices *desired by [Johnson]* and consult with [Johnson] on any changes[;]" and "[d]etermin[ing], in accordance with the Benefit Program and claims administration procedures and practices, the qualification of claims submitted, making, as requested by [Johnson], such investigations as may be necessary." *Id.* (emphasis added). Additionally, Provident agreed to

> *Refer to [Johnson], for consideration and final decision, any claim or class of claims [Johnson] may specify*, including claims involving:
>
> > 1) Questions, with respect to qualification of claims submitted under the terms of the Benefit Program,
> > 2) Questions, with respect to the amount due, and
> > 3) Controversy,
>
> with an analysis of the issues to assist [Johnson] in reaching a decision.

Id. (emphasis added).

It is evident that the ASA was drafted broadly so as to allow Johnson and Provident considerable flexibility concerning the tasks Provident would carry out in administering the STD plan. Provident was not constrained to follow specific and detailed claims procedures; rather, the company was authorized to follow the claims administration procedures and practices "desired by" Johnson. Further, Provident was required to refer to Johnson for final decision only those claims as Johnson "may specify." These provisions empowered Provident to handle appeals, if Johnson wished. Apparently, Johnson did so desire, considering that Provident handled Leggett's claim all the way through final appeal with Johnson's knowledge and acquiescence. Accordingly, although the STD plan provided that Johnson had "the right of final review and decision on all claims," Doc. 32, Ex. "A," PLAGP00928, Johnson delegated to Provident the extremely broad discretionary claims determination authority Johnson enjoyed under the ERISA section of the STD plan.[10] Moreover, apart from the ASA, regardless of which company was to serve as the final decisionmaker, the emphasized language in the ERISA section of the STD plan makes clear that appeals of claims denials are to be reviewed under an arbitrary and capricious standard.

Further, the Court concludes that the "pure" variety of arbitrary and capricious review applies to Provident's ultimate claim denial decision. Heightened arbitrary and capricious review is inapplicable because Johnson did not have even a potential conflict of interest. It is

[10]The Court rejects Leggett's conclusory suggestion that this contractual delegation constituted a breach of fiduciary duty by the Defendants.

true that the ASA makes clear that Johnson was responsible for furnishing funds to pay claims. In that regard, the agreement states: "[Johnson] shall provide funds to be used to make Benefit Program payments to participants as funds are needed to cover such payments. It shall be [Johnson's] responsibility to provide funds sufficient to cover checks validly issued." Doc. 32, Ex. "D," PLAGP00937. This is consistent with the STD plan itself, which states: "[Johnson] is solely responsible for payment of STD Benefits payable under the terms of this Plan." *Id.*, Ex. "A," PLAGP00928. However, in its summary judgment motion, Johnson states that its assets were at risk only if employee-contributed premiums held in a trust fund were insufficient to cover STD claims. *See* Doc. 33 at 6. This representation stands unrebutted. In any event, even though the potential existed that Johnson's funds would be used to pay STD claims, the plan was actually administered by Provident under the ASA. Because claims decisions were actually made by Provident, not Johnson, the "pure" arbitrary and capricious standard applies. Given this conclusion, it is unnecessary to decide whether Johnson's claims funding structure would compel heightened arbitrary and capricious review if Johnson had actually functioned as claims administrator.[11]

[11]However, if the heightened arbitrary and capricious standard, or even the *de novo* standard, did apply, the outcome would be the same for the simple reason that no reasonable fact-finder could conclude that the STD claim denial decision was "wrong."

B. LTD Plan

Unlike the situation involving the STD plan, there was no ASA between Johnson and Provident concerning the LTD plan. Instead, as previously stated, the latter plan was both insured and administered by Provident.

Like the STD plan, the LTD plan states: "Proof of Loss means written evidence satisfactory to [Provident] that Covered Persons are Disabled and entitled to LTD Monthly Benefits." Doc. 32, Ex. "C," PLAGP00849. Again, this language is sufficient to trigger arbitrary and capricious review. *See Morency,* 2001 WL 737531 *2-3; *Donato,* 19 F.3d at 379-80.

The LTD plan also contains the following other provisions pertinent to the standard of review question:

> ALLOCATION OF AUTHORITY
> Except for those functions that this Policy specifically reserves for the Policyholder,[12] the Policyholder delegates and agrees that we[13] shall have full, exclusive, and discretionary authority to control, manage, and administer claims, and to interpret and resolve all questions arising out of the administration, interpretation, and application of this Policy.
>
> Our authority includes, but is not limited to, the following:
>
> 1. the right to resolve all matters when a review has been requested;
> 2. the right to establish and enforce rules and procedures for the administration of this Policy and any claim under it; and
> 3. the right to determine:

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[12]The policy identifies Johnson as the policyholder. *See* Doc. 32, Ex. "C," PLAGP00869.

[13]The policy specifies that "we" refers to Provident. *See* Doc. 32, Ex. "C," PLAGP00869.

a. eligibility for coverage;
b. entitlement to benefits;
c. amount of benefits payable; and
d. the sufficiency and amount of information we may require to determine a, b, or c.

Subject to the review procedures of this Policy, any decision we make in the exercise of our authority is conclusive and binding.

Id., PLAGP00847 (footnotes added).

Under *Kirwan,* this language vested Provident with sufficient discretionary authority to compel application of the arbitrary and capricious standard of review. However, since Provident both pays and administers claims under the LTD plan, the heightened version of arbitrary and capricious review is warranted. As previously stated, the threshold determination under this standard is whether the fiduciary's interpretation is "wrong" from the perspective of *de novo* review. *See Godfrey*, 89 F.3d at 758.

VI. ANALYSIS

A. STD Claim

Applying the "pure" arbitrary and capricious standard of review, the pertinent issue is not whether Leggett actually had MS in May 2001, or whether she is now disabled from that disease, or even whether she was disabled shortly after Johnson laid her off. It is also irrelevant that Leggett might not have been able to return to work because of her MS.[14] If the *de novo* standard applied, the relevant question would be whether Leggett met the STD plan's definition of disability while she was covered under the plan. However, under "pure" arbitrary and

[14]Of course, Leggett did not have a job at Johnson to return to following her layoff.

capricious review, the only pertinent issue is whether, based on the information known to Provident at the time the company rendered its decision, it was reasonable for Provident to decide that Leggett was not disabled while she worked for Johnson. Stated even more precisely, at this stage in the case, the Court must determine whether there are any genuine issues of material fact precluding summary judgment on that question.

As previously noted, the STD policy provided that Leggett's coverage automatically ceased on the date Leggett's employment with Johnson terminated. *See* Doc. 32, Ex. "A," PLAGP00916. That date was May 11, 2001. Even though May 9th was the last day she actively worked, she was on FMLA leave on May 10th and 11th, and Johnson had made her termination effective May 11th. Accordingly, Leggett's STD coverage ended on May 11, 2001.

In order to qualify for STD benefits, Leggett must have been disabled under the STD policy's definition on May 11, 2001. That is, due to sickness or injury, she must have been unable to perform each of the material duties of her position as an assistant auditor with Johnson. *Id.*, PLAGP00922. Leggett has not disputed that this was a sedentary job.

As a matter of law, the Court determines that Provident's decision was not arbitrary and capricious; no reasonable fact-finder could conclude otherwise. It is undisputed that Leggett was working in her job at Johnson during the week of her layoff. When Dr. Newman saw Leggett on May 7, 2001 because of Leggett's concern that she might be susceptible to an aneurysm, the doctor noted no circumstances suggesting Leggett could not perform her job. He remarked that Leggett was "having no trouble with thinking, cranial nerve functions, motor function, other that what she has had before." *Id.*, Ex. "B," UPCL00027. In fact, Newman

stated that Leggett was asymptomatic except for hypertension. Nevertheless, Newman ordered an MRA.

Two days later (May 9th), Leggett reported to work as usual and was informed she was terminated effective May 11th. There was no indication whatsoever on May 9th that Leggett could not perform her job duties. That same day, she underwent a limited MRI brain scan. The results of that test prompted Dr. Newman to state that "[*c*]*onsideration must be given* to multiple sclerosis." *Id.*, UPCL00024 (emphasis added).

The next day (May 10th), Leggett underwent an MRI brain scan, with and without contrast. This test disclosed "multiple white matter lesions" that Dr. Newman believed "*likely* represent multiple sclerosis plaques in this age group." *Id.*, UPCL00025 (emphasis added). However, Newman also added: "Clinical correlation is warranted." *Id.*

Despite the fact that Dr. Newman's notes indicate he had not yet reached a definitive diagnosis of MS on May 10th, Newman furnished Provident with an Attending Physician's Statement of Disability (APS) bearing that very same date, stating that Leggett did have MS. Therein, notwithstanding any prior indication that Leggett could not perform her job as an assistant auditor, Newman further noted that Leggett was totally disabled from her own occupation *and any other work*; that May 9th - a day on which Leggett had actually worked before being notified of her termination - was the date on which her total disability commenced; and that Leggett was incapable of performing all of the duties of her occupation.

Notwithstanding this statement by Dr. Newman on May 10th, it is apparent that by June 11th Newman still had not reached a definite conclusion regarding a diagnosis of MS. In that

regard, his office notes for that date state that the "multiple white matter lesions . . . *appear to be* multiple sclerosis." *Id.*, UPCL00039 (emphasis supplied). Newman further remarked that Leggett "*probably* does have a *mild* case of MS *but I would like to be firm on this* so we can intervene properly." *Id.* (emphasis supplied). These circumstances entitled Provident to consider with considerable skepticism Dr. Newman's statements in the APS concerning disability.[15]

Despite all the medical information concerning Leggett's symptoms following her layoff, it was not unreasonable for Provident to conclude that Leggett was not disabled *before* May 11th, the day her coverage ceased. Notwithstanding Dr. Newman's APS, there was no evidence that Leggett could not *actually* perform the *particular* duties of her job before that date.[16] The

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[15]Dr. Martinez was a bit more conservative in his approach than Dr. Newman. Concerning any linkage between Leggett's prior medical problems and the MS diagnosis, the most that Martinez was willing to say (in October 2001) was that since 1994, Leggett had symptoms that "*could have been* attributed to" MS, and it was "*conceivable* that the complaints and findings of the previous years *could have been* directly related" to the "recent[] diagnos[is]" of MS. *Id.*, UPCL00071 (emphasis supplied).

[16]Under the "pure" arbitrary and capricious review standard, the Court is limited to considering the information before Provident at the time the company denied Leggett's claim. Accordingly, the Court cannot consider Leggett's recently-submitted affidavit or the other documents she filed in opposition to the summary judgment motions in evaluating the reasonableness of Provident's decision concerning STD benefits. However, even if these materials could properly be considered, they are insufficient to defeat summary judgment because they do not create a genuine issue of material fact concerning whether Leggett could perform her job duties before she was terminated. The closest Leggett comes to touching on that subject in her affidavit is to state: "During nearly the whole last year working for Johnson, I did little more than make copies from a xerox machine. The other employee working with me had to do most of the work because I kept bumping into things and forgetting what I was doing." Doc. 47, ¶ 8. However, this statement is too vague, conclusory and temporally imprecise to create a fact issue on this point. Additionally, Leggett offers nothing correlating this behavior to MS, as opposed to other medical problems she suffered while working for Johnson.

undisputed evidence is that she *was* working on May 9th, the day of her layoff notification. Dr. Newman's office note for May 7th reflected no problems concerning Leggett's ability to work. Yet, three days later, Newman signed an APS reporting that Leggett was fully disabled as of May 9th from her own job and any other work. Moreover, despite Newman's statement in the APS that Leggett was disabled as of May 9th, the physician had not even reached a firm MS diagnosis a month later. Further, Leggett's lumbar puncture and evoked response test results were negative. Finally, the timing of Leggett's claim is not something Provident could have been expected to ignore.

Under these circumstances, Provident's claim denial decision was not unreasonable, as a matter of law. Accordingly, the Court determines that Provident and Johnson are entitled to summary judgment on Leggett's claim concerning denial of STD benefits.

B. LTD Benefits

Provident argues that because Leggett has never submitted a claim for LTD benefits, she is precluded under the exhaustion of remedies doctrine from seeking benefits under that policy. The LTD plan unambiguously requires a claimant to submit a claim via a claim form or by letter. *See* Doc. 32, Ex. "C," PLAGP00849 It equally clear that Leggett has never submitted a claim.[17]

[17]Leggett complains that the Defendants never provided her with a claim form; however, there is no evidence she ever asked for one. Leggett also argues that the Defendants had a duty to spontaneously furnish her with the required form. The Court rejects this proposition. The LTD plan clearly contemplates that Provident will furnish claim forms in response to a request from a covered person. *See* Doc. 32, Ex. "C," PLAGP00849 ("If Covered Persons do not receive our forms within 15 days *after they ask for them*, they may submit their claims in a letter to us" (emphasis supplied)).

It is well-settled in the Eleventh Circuit that an ERISA plaintiff must exhaust available administrative remedies prior to initiating suit in federal court. *See Perrino v. Southern Bell Tel. & Tel. Co.*, 209 F.3d 1309, 1315 (11th Cir. 2000). This rule is strictly enforced. *Id.* However, it is subject to narrow exceptions "reserved for exceptional circumstances." *Id.* One of those exceptions is where resort to administrative remedies would be "futile." *Id.* at 1316. However, "if a reasonable administrative scheme is available to a plaintiff and offers the potential for an adequate legal remedy, then a plaintiff must first exhaust the administrative scheme before filing a federal suit." *Id.* at 1318.

In response to Provident's failure-to-exhaust argument, Leggett maintains she is excused from that requirement because filing a claim for LTD benefits would have been futile. However, in order to raise the futility exception, Leggett was required to have pled it. *See Byrd v. MacPapers, Inc.*, 961 F.2d 157, 160-61 (11th Cir. 1992) (determining no abuse of discretion regarding dismissal based on "finding that plaintiff failed to plead exhaustion of administrative remedies or impossibility"); *Variety Children's Hosp., Inc. v. Century Medical Health Plan, Inc.*, 57 F.3d 1040, 1042 & n.2 (11th Cir. 1995) (upholding district court's dismissal of ERISA benefits count where plaintiff "neither pleaded nor recited facts showing that it had exhausted its administrative remedies under the plan[,]" or pleaded "that exhaustion is waived because it would be futile"). Leggett did not do so; her Second Amended Complaint is devoid of any allegation that exhaustion of administrative remedies would have been futile. Accordingly, Leggett has waived her ability to argue futility.

Even absent that waiver, Leggett has not presented any facts demonstrating exceptional circumstances so as to warrant application of the narrow futility exception. At the outset, the Court is compelled to note that Leggett didn't just fail to exhaust her administrative remedies; she failed to even *initiate* the process by filing a claim. How could Provident have been expected to begin evaluating a claim for LTD benefits when no claim was ever filed? Moreover, while it is true that Provident had concluded Leggett was not disabled in connection with its review of her STD claim, that did not necessarily mean the company was certain to reach the same conclusion had Leggett submitted an LTD claim. More importantly, there is no indication whatsoever that the company would not have fairly and thoroughly evaluated a claim for LTD benefits, had Leggett bothered to file one. Indeed, the manner in which Provident handled Leggett's STD claim suggests the company would have fairly considered an LTD claim. During the process of assessing Leggett's STD claim, Provident accepted Leggett's and her physicians' submissions, evaluated them along with other information, and sent Leggett correspondence explaining its reasons for denying her claim. Moreover, each and every time Leggett sought reconsideration or appeal of Provident's initial decision, or submitted additional medical information, the company reassessed that decision. In sum, because there was a reasonable administrative scheme available to Leggett which offered the *potential* for an adequate legal remedy, *see Perrino,* 209 F.3d 1318, Leggett was required to avail herself of that

scheme before resorting to litigation. Here, application of the futility exception would eviscerate the exhaustion requirement.[18]

Finally, even if Provident were not entitled to prevail on exhaustion grounds, the company would nevertheless be due summary judgment on the question of whether Leggett was disabled while she was still covered under the LTD plan. Again, since the heightened arbitrary and capricious standard applies to the LTD policy, the Court applies *de novo* review as a threshold matter. Viewing all of the evidence submitted in connection with the summary judgment process, and drawing all inferences in Leggett's favor, the Court determines that no reasonable fact-finder could conclude that Leggett was disabled while she was covered under the LTD policy. There simply is no evidence that Leggett could not *actually* perform the *specific* duties of her sedentary job as an assistant auditor, or that she was unable to earn at least the LTD plan's Own Occupation Income Level, before her LTD coverage expired on May 11, 2001.

Based on the foregoing, the Court determines that Provident and Johnson are entitled to summary judgment on Leggett's claim for LTD benefits.

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[18]However, it *would* be futile to remand this matter to Provident so that Leggett could attempt to exhaust administrative remedies. The LTD plan's time limit for filing a claim expired long ago. *See* Doc. 32, Ex. "C," PLAGP00849. In that regard, the plan requires a claimant to submit proof of loss within 90 days after the end of the 180-day elimination period. *Id.* However, if a claimant cannot do so, proof of loss must be submitted when reasonably possible, but not later than one year after the 90-day period. *Id.* The plan makes clear that if a proof of loss is filed after that deadline, the claim will be denied. *Id.* Hence, any claim by Leggett for LTD benefits is now undisputably time-barred. Under these circumstances, remand would constitute a useless formality.

C. Breach of Fiduciary Duty

The Second Amended Complaint also contains a breach of fiduciary duty count. *See* Doc. 26, Count II, at unnumbered third and fourth pages. However, that count really does nothing more than challenge the Defendants' actions in denying Leggett benefits. Further, the prayer for relief in Count II contains a request for payment of benefits. *Id.*, ¶ 17. Hence, Count II does not appear to allege wrongs different from those asserted in Count I; the former count is essentially also a claim for benefits under the employee plans at issue in this case.

In any event, even if Count II could be viewed as alleging wrongs independent of the benefit denial decision, that count would be barred because there is no indication Leggett exhausted her administrative remedies as to any such separate allegations. *See Perrino,* 209 F.3d at 1315 n.6 ("We apply this exhaustion requirement to both ERISA claims arising from the substantive provisions of the statute, and ERISA claims arising from an employment and/or pension plan agreement"); *D'Amico v. CBS Corp.*, 297 F.3d 287, 291 (3rd Cir. 2002) (requiring exhaustion of ERISA breach of fiduciary duty claims where the alleged statutory violation "is actually a claim based on denial of benefits under the terms of a plan").

Accordingly, the Defendants are entitled to summary judgment on this claim, as well.

VII. CONCLUSION

Based on the foregoing, it is ORDERED as follows:

1. Defendant Provident's Motion for Summary Judgment (Doc. 32), filed November 28, 2003, is GRANTED.

2. Defendant Johnson's Motion for Summary Judgment (Doc. 33), filed December 1, 2003, is GRANTED.

3. Defendant Provident's Unopposed Motion for Leave to File Reply to Motions for Summary Judgment, or in the Alternative, Motion for Oral Argument (Doc. 52), filed January 22, 2004, is DENIED. The Court determines that neither a reply nor oral argument is necessary in this case.[19]

4. Defendant Provident's Motion to Strike (Doc. 53), filed January 22, 2004, is DENIED. Since it was necessary for the Court to apply the heightened arbitrary and capricious standard of review to the LTD policy, requiring a threshold *de novo* determination, and for record completeness purposes, the subject documents should remain in the court file.[20]

5. Any other pending motions are moot.

6. The Clerk shall enter a final judgment providing that the Plaintiff, Judi M. Leggett, shall take nothing on her claims against the Defendants, Provident Life and Accident Insurance Company and Johnson Controls World Services, Inc., and further providing that the Defendants shall recover their costs of action.

7. The Clerk shall close this case.

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[19]This ruling applies to Johnson's Notice of Joinder (Doc. 54) in this motion.

[20]This ruling also applies to Johnson's Notice of Joinder.

DONE and **ORDERED** in Chambers, in Orlando, Florida this 9th day of February, 2004.

ANNE C. CONWAY
United States District Judge

Copies furnished to:
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F I L E C O P Y

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